Paving the Way to Integrated Care

Diabetes Cardiovascular Risk Management Program (DCRMP)

The DCRMP is a DHS funded Hospital Admission Risk Program. It commenced in January 2004 and is now part of the mainstreamed HARP Program. The program was auspiced by the South East Primary Care Partnership. The Dandenong District Division of General Practice was the lead agency and fund holder. Southern Health acute and primary care were partners in this program.

The DCRMP was designed to enhance the care of individuals with type 2 diabetes and significant cardiovascular risk/ disease. One of the key features of the model was to support GP's in their role as care coordinators within a multi-disciplinary team. In addition the aim was to streamline the flow of consumers between health-care providers as well as promoting the self-management and empowerment of those living with these conditions. The program aimed to reduce the hospital presentations and admissions of this target group.

Recruitment to date (Aug 06):

- 498 consumers
- 264 (57%) referred directly via the GP stream involving 146 individual GPs
- (43%) referred directly via the acute sector
- 240 GPs are involved in referral and/or ongoing care

Project services

Project services were developed in collaboration with consumers and partner organisations across the service system. Service development linked patient needs with local knowledge and expertise. Service development was informed by the latest evidence/ best practice.

Services include:

- Central coordination and assessment service
- Support & recommendations to GPs when addressing more complex needs associated with diabetes & CVD
- Assistance with insulin initiation and stabilisation
- Access to an inter-disciplinary advisory clinic at Dandenong Hospital
- Access to self-management programs and other lifestyle opportunities

This program was highly commended in the category of *Excellence in Continuity of Care* at the Victorian Public Health Awards held in October 2006

Central Coordination Service (DCAS)

The central coordination & assessment service located at the Division of GP is central to the success of the program. It supports and enhances an effective system of service coordination and delivery by providing a dynamic interface between the patient and service providers. In particular DCAS staff help mediate the cultural differences between GP practices and health care providers working in community health and the acute setting. This promotes and facilitates a smooth patient journey.

The primary function of DCAS is to receive referrals, assess, triage, track and monitor patients as they move through the service system. Referrals are received directly from GPs and specific areas of the Dandenong Hospital. Assessment processes ensure consumer needs are matched appropriately to available services.

DCAS provides GPs with a standardised referral process incorporating the use of the Statewide Service Coordination Tool templates. All GPs referring to this program use these Tool Templates.

Key Results

- 1% reduction in HbA1c from baseline to year 1 (p = 0.50)
- Significant increase in HDL (p = .007)
- Significant increase in patient's ability to access appropriate support
- Reduction of $1700 per participant hospitalisation cost

The Division has coordinated GP engagement for this program and benefits from supporting its members as a system facilitator and partner in health care delivery. The following highlights some of the successful GP engagement strategies used.

- GP ownership – representation during planning, implementation and maintenance
- GP "champion" involved at reference group level
- Inclusion of practice staff in the engagement strategy
- Support from division staff with rapport & understanding of general practice environment & culture
- Project Management staff located in Division – increased opportunistic access to GPs
- Destination for referral (DCAS) seen as GP friendly and supportive
- Adequate remuneration for GP involvement in development and planning

The project has clearly demonstrated the ability to coordinate and better integrate diabetes cardiovascular services across the acute and primary care service system. This has been achieved in the context of maintaining the GP as the care coordinator.

This project has recently been 'mainstreamed'. The Dandenong Division continues to work collaboratively with Southern Health in providing access to a range of high quality integrated services to this high risk target group.

Feedback from Practices referring to DCRMP

"The Diabetes Coordination & Assessment Service (DCAS) staff know how to relate to GPs. I am confident the service combines assisting the welfare of the patient while supporting the GP role. It is a great conduit to appropriate patient services"
(GP in Dandenong)

"I like the feedback from DCAS as it compliments the recall and reminder system in place at the practice"
(Practice Nurse in Berwick)

"The Diabetes Self Management Program really helped [the patient] to understand diabetes and self management"
(GP at Narre Warren)

"I feel confident that patients are moving through the services and receiving quality information."
(Practice Nurse in Berwick)

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Enhancing program delivery through inter-divisional collaboration

The Eastern Region Divisions Network (ERDN) consists of Eastern Ranges GP Association, Inner Eastern Melbourne, Knox and Whitehorse Divisions of General Practice. The Divisions have been using a collaborative approach to enhance a number of Division programs over recent years. Each of these programs has been highly successful, and has increased the overall capacity of individual Divisions to provide a wider range of services to the GP Members.

There are many benefits to working together. Staff from each Division have had the benefit of being exposed to the varying cultures of the other Divisions. They can also experience first hand the complexities and proficiencies demonstrated in differing environments and circumstances.

Sharing of expertise between staff greatly contributes to each Division's success in programs, and also adds to the skills of individual Divisions' staff groups. It can be positive, too, to mix up the roles and responsibilities of managerial and operational staff, who are then able to participate in vertical learning. In this way, project staff are able to access professional development well beyond what can be learned within one Division.

Another practical benefit of working together is an increase in GP numbers attending activities, while not quadrupling the workload. While it is still important to maintain individual identity, and to continue to run programs and events at a local level, for activities that easily cross the borders of other Divisions it can be a more efficient and effective method of delivery.

Working together can increase consistency and efficiency through cost savings, which not only benefits our organisations, but also other strategic partners with whom we share common boundaries, such as DHS and other health care services. Relevant strategic partners have the opportunity to reach many more GPs than would be accessible through single Division activities. The ability to promote and present a united front to various regional stakeholders is important. These stakeholders are able to liaise at one point, yet access all four Divisions and present their message to a larger audience than would otherwise be possible.

To date this has been achieved by allocating one Division as fundholder and coordinator of each project so that the reporting and direction of the program is clear. This is a role that is shared across the four Divisions, and allows each Division to choose the lead role in an area in which they have strength, allowing the other Divisions to draw on that strength.

Standard templates have been designed and are in use across a range of inter-Divisional activities. These templates are consistently reviewed, as we learn more about each other and how interdivisional activities should be organised.

The Eastern Region Divisions Network is looking to the future with optimism, aiming to strengthen the partnership and work together wherever beneficial and appropriate. Steps are in place to continuously improve this collaboration and to strengthen it for the many projects to come.

GPs enjoying a break at the recent Eastern Region Divisions Network GP and Family conference, titled *Developments at the Coal Face: What's New in General Practice.*

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Northern network nurtures new arrivals

The Refugee Health Services Project at the Northern Division of General Practice

Working with newly arrived refugees can involve managing rarely-encountered diseases, complex immunisation catch-ups, and caring for people traumatised by war, who speak little English. In the past, many of these patients have been initially cared for by Community Health Centre doctors and their colleagues. With today's GP workforce shortages, this is not always possible. A new partnership in Melbourne's northern suburbs is addressing these issues by cooperation between community health, general practice and settlement agencies.

The Department of Human Services (DHS) has funded Primary Care Partnerships (PCPs) to make sure that newly arrived refugees can effectively access the range of health services they need. This project supports the refugee health nurse project, which has placed nurses in Community Health Centres that see high numbers of recent refugees. The North Central Metro Primary Care Partnership (NCMPCP) is conveniently co-located with the Northern Division of General Practice and has engaged the Division's assistance to carry out the new project. The existing close relationships with Darebin Community Health and with local settlement services, together with an active group of interested general practitioners already meeting regularly in the Division's Refugee Small Learning Group, have facilitated the smooth and speedy development of the Refugee Health Services Project.

Workforce shortages, together with the complex health needs of most newly arrived refugees, means that GPs in Community Health Service GPs are overstretched, so the program aims to build expertise and interest in local private general practice to share the load. Interested GPs, practice nurses and practice managers attended a three-part Active Learning Module run with Foundation House at the Division with the support of local settlement services and Darebin Community Health. GP consultant Dr Joanne Gardiner is working with Division Program Coordinator Nancy Atkin to prepare a Refugee Resource Kit (with concise information such as referrals, screening, and Medicare Items) for practices; this information and more is being put on the Division's website, www.ndgp.org.au. The Division is offering practice visits by Dr Gardiner, to conduct training or provide resources according to the needs of the particular practice.

Dr Jo Gardiner, GP Consultant

This small project, scheduled for completion by the end of 2006, has already had a number of positive outcomes. For GPs, it is building awareness and relevant knowledge to work with refugee patients, and supplying practical tools for example for screening. Information on care pathways, and on the assistance available from the refugee health nurse, supports GPs and their staff in providing better care for their patients. Workforce issues are being addressed in a small way, by building skills of private GPs, and training practice nurses to share work for example in initial screening.

These resources and training opportunities have been promoted widely in Division publications. At the same time, partner agencies such as the North East Migrant Resource Centre, and AMES and Darebin Community Health hear from their clients about GP practices commonly attended by various clients from various refugee backgrounds. Working together and sharing this information has enabled the project to target practices that have appreciated the offer of additional resources and training; as well as enlisting the additional practices to help share the workload.

Newly arrived refugees have their settlement needs coordinated by AMES, whose local coordinator, Nihad Aganovic, is based at the Migrant Resource Centre in Preston. Nihad has the challenging task of arranging initial health assessments for new arrivals. He has been keen to work with the Division to streamline this process, and the new partnership has already assisted him to find GPs with appropriate language skills in the right locations for his clients.

Refugee Health Services Project Reference Group

The Division had already brought together GPs interested in refugee health over the past three years, through our Refugee Health Small Learning Group. The Refugee Health Services project has created a wider network, linking GPs with local organisations responsible for the care and settlement of newly arrived refugees. It has also highlighted the gaps in the system, with new refugees being settled on the urban fringe, beyond the official catchment of Darebin Community Health, in areas with fewer GPs and further from specialist health services.

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